STATEMEN	VI OF DEFICIENCIES	TH AND P AN SERVICES RE & MEDICAID SERVICES	459	5/1./11	FORM OMB NO	APPROVI 0. 0938-03
NO PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	SURVEY
		445276	B. WING _			00/0044
	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE		30/2011
CUMBE	RLAND VILLAGE CA	ARE AND REHABILITATION CENTER	R 1	36 DAVIS LANE .AFOLLETTE, TN 37766		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES	(QI		N OF CORRECTION	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE JENCY)	COMPLETIO DATE
F 000	INITIAL COMMEN	NTS	F 000	"This Plan of Correc	tion is prepared	
				and submitted as req	non is prepared	-
	An annual recertifi	ication survey and complaint		and submitted as requ	of Compatient	
	Were completed at	6942, 27119, 27283, 27617,		submitting this Plan	or Correction,	
	Rehabilitation Con	Cumberland Village Care and		Cumberland Village		
	deficiencies were	iter on March 28-30, 2011. No cited for the complaint		Rehabilitation Center		į
	investigations.	oned for the complaint		that the deficiency lis	sted on this form	1
F 322	483.25(g)(2) NG T	REATMENT/SERVICES -		exist, nor does the Co		
S\$=D	RESTORE EATING	G SKILLS	F 322	statements, findings,	facts, or	ì
į				conclusions that form	the basis for the	İ
	Based on the comp	prehensive assessment of a	ļ	alleged deficiency. T	The Center	
	resident, the facility	v must ensure that a resident	i	reserves the right to o	challenge in legal	!
ì	who is led by a nas	so-gastric or gastrostomy tube	2	and/or regulatory or a	odministrativa	
i	to prevent assisting	priate treatment and services		proceedings the defic	laministrative	
3	Vomiting dehydratic	on pneumonia, diarrhea, on, metabolic abnormalities,	j'	statements facts and	iency,	
	and nasal-pharynge possible, normal ea	eal ulcers and to restore if	f	statements, facts, and form the basis for the	deficiency."	
1]1	F 322 - (D)		
:	this REQUIREMEN	NT is not met as evidenced	i.			
		opped souless at]]	l. Resident #13 was	re-assessed by	
i ·	facility policy review	ecord review, observation, , and interview, the facility	t	he Director of Nursir	ng Services on	
į i	failed to check place	ement of a feeding tube prior	3	3/29/11 with no adver	se findings. The	
1	to administration of	medications, and failed to	t	ube feeding for reside	ent #13 was	
: 1	maimain clean techi	nique while giving medications	c	hanged by the Direct	or of Nursing	
	inough the reeding	tube for one resident (#13) of	S	Services on 3/29/11.	LPN #1 was	
	thirty-two residents i	reviewed.	p	rovided re-education	on 3/29/11 by	
	The finding is store t		ltl	ne Regional Director	of Clinical	
1	The finding included		ic	perations regarding	infection control	
F	Resident #13 was re	eadmitted to the facility on	te	echnique related to pe	aroutonosus	
i J	anuary 22, 2011, w	ith diagnoses including Late		ndoscopio gostrostan	AN (DEC) (class	
-	thects of Cerebral V	/ascular Accident	7	ndoscopic gastroston	ry (red) tubes.	
i L	typertension, Diabe	tes, Alzheimer's Disease		PN #1 was re-educat	ea by the	
ុជ	no Dysphasia. Con	ntinued medical record review	بارا	Director of Nursing Se	ervices on 4/1/11	
1.0	i the Minimum Data	Set dated January 22, 2011	re	garding maintaining	clean technique	20
7.170	vealed the resident	t received nutrition through a	W	hile giving medication	ons through the	
*ATORY D	RECTOR'S OR PROVIDE	RISUPPLIER REPRESENTATIVE'S SIGNAT			=======================================	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DEWF11

Facility ID: TN0703

If continuation sheet Page 1 of 7

DEPARTMENT OF HEAL	TH AND HI " AN SERVICES			DDINITER	0: 04/04/201
CENTERS FOR MEDICAL				FORM	APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO	. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	SURVEY
	445276	B. WING		}	
NAME OF PROVIDER OR SUPPLIES				03/3	30/2011
- Hamilton Same		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERLAND VILLAGE CA	ARE AND REHABILITATION CENT	ER	136 DAVIS LANE		
	1014080 NOTE 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		LAFOLLETTE, TN 37766		
TAG REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	UDDE	COMPLETION DATE
F 322 Continued From p	page 1	F 00			
percutaneous end	loscopic gastrostomy (PEG)	F 32	feeding tube and checking place	ement	
tube, and was total	al dependent for all activities of		of a feeding tube prior to		
daily living.	Top an activities of		administration of medications.		
Obannus			2 0		
the resident's room	arch 29, 2011, at 7:50 a.m., in		2. Current residents with (PEG)) tubes	
Nurse (I PN) #1 ac	m, revealed Licensed Practical		were re-assessed by a licensed	nurse	
resident. Continue	ed observation revealed LPN#1		on 3/30/11 with no adverse find	lings.	
i gracounected tue t	Uping from the PEG and			İ	
: without checking p	lacement of the feeding tube		3. The Staff Development		
administered Wedi	cation through the feeding		Coordinator will complete re-		
tube,			education with licensed nurses	on	
Review of the facili	the malia. E		maintaining clean technique wh	ile	
revealed Impleme	ty policy Enteral Nutrition entation2,b, for continuously		giving medications through the		
tube fed clients, tes	st placement every 4 to 12		feeding tube and checking place	ment	
hours and before m	nedication administration.		of a feeding tube prior to	one	
		7	administration of medications.	Clair i	1
Interview with LPN	#1 on March 29, 2011, at 8:15		education will be completed by	11112	
the feeding tube way	r, confirmed the placement of		4/15/11.	i	
administration of m	edications,	ž.	1 The Director - 5 N		
Further observation	at the time of medication		4. The Director of Nursing Serv	nces,	
administration revea	aled LPN #1 disconnected the		Assistant Directors of Nursing	ĺ	
rabing nom the PEC	a. Graped the tubing over the		Services, Staff Development	200 70	
side rall of the bed.	and flushed the PEC	i	Coordinator, or Pharmacy Const	ultants	
fallen to the firm of	ion revealed the tubing had		will observe medication		1
i rement to the 11001. C	Ontinued observation		administration opportunities with		1
mattress went to the	layed the tubing on the bed e bathroom, wet a paper	i	gastrostomy tubes (3) times wee	kly	
towel, returned to the	e bedside, wiped the tubing		for (4) weeks and (1) time month	ily for	İ
with the wet baber to	owel and reconnected the		(2) months to monitor for checki	ing	
tubing to the PEG.	33,000		placement of the feeding tube an	d	
Terrange was as	s		maintaining clean technique. Th	ie	
Assistant Di	rector of Nursing (DON) and	j	Director of Nursing Services or		
vesisiant pliector of	Nursing (ADON) on March	1.	Assistant Director of Nursing Sci	rvices	
confirmed class to the	n., in the DON's office,	į,	will present findings from gastro	otomi	

confirmed clean technique was not followed for

Assistant Director of Nursing Services will present findings from gastrostomy

tube medication administration

PRINTED: 04/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRU	CTION	(X3) DATE	SURVEY LETED
	1	445276	B. WING)	(20)2011
	PROVIDER OR SUPPLIER ERLAND VILLAGE CAP	RE AND REHABILITATION CENT	ER	REET ADDRESS 136 DAVIS LAN LAFOLLETTE		The same of the sa	/30/2011
(X4) ID PREFIX TAG	. (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PRO'	OVIDER'S PLAN OF CORR CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOLLI D BE	(X5) COMPLETION DATE
	Continued observation of me Further observation of me fulbing from the PEG side rail of the bed, a Continued observation of me furthers, went to the with the wet paper to tubing to the PEG. Interview with LPN#1 imattress, went to the with the wet paper to tubing to the PEG. Interview with LPN#1 imattress, went to the with the wet paper to tubing to the PEG. Interview with the Director of New Years and the PEG.	scopic gastrostomy (PEG) dependent for all activities of rch 29, 2011, at 7:50 a.m., in revealed Licensed Practical ministering medications to the diobservation revealed LPN#1 bing from the PEG and accement of the feeding tube ation through the feeding y policy Enteral Nutrition intation2.b. for continuously placement every 4 to 12 edication administration. 1 on March 29, 2011, at 8:15 confirmed the placement of a not checked prior to dications. at the time of medication led LPN #1 disconnected the draped the tubing over the nd flushed the PEG	F 322	Improvement three mont Improvement the Administra Services, Manager, Manager, Manager, Foundation Manager, Focial Servicetor, ar Subsequent implemente	g to the Process ent Committee me ths. The Process ent Committee co istrator, Director of Medical Director, ator, Assistant Director, Assistant Director, Clinical Co MDS Coordinator, m Manager, Busin Housekeeping and infection Contro vice Director, Acti and Pharmacy Con- t plans of correction ed as necessary ba ation results.	ensists of of Nursing Assistant rectors of Case , Health less Office I Laundry of Nurse, ivities sultant, on will be	4/18/11

DEPAR	TMENT OF HEALT	H AND H' \N SERVICES				PRINTE	0: 04/04/2011
		E & MEDICAID SERVICES				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION	(X3) DATE COMPI	
		445276	B. WING	;			
NAME OF	PROVIDER OR SUPPLIER			TDEET			30/2011
СИМВЕ	RLAND VILLAGE ÇA	RE AND REHABILITATION CENT	ER	136 DAV	DRESS, CITY, STATE, ZIP CODI S LANE ETTE, TN 37766	E	
(X4) ID PREFIX TAG	: ⟨®ACH DEF(CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION COSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 322	Continued From pa	age 2	F 32	12			1
	the tube feeding di	sconnect, and verified the e changed after touching the	, 52		w.		
F 371 SS=F	483.35(i) FOOD PI STORE/PREPARE	ROCURE, :/SERVE - SANITARY	F 37	F 371		75	
	authorities; and	om sources approved or story by Federal, State or local distribute and serve food litions		from t by the 3/28/1 165 de mainta minim educat 3/30/1	hot food items were re he tray preparation ste. Nutritional Service Di I and were re-heated to grees prior to serving lined above 141 degree um holding temperature ion was provided to Co I by the Nutritional Se	am table irector on o above and es re. Re- ook #1 on rvice	
	by. Based on observation failed to maintain the	on and interview, the facility proper holding temperature ms on the tray preparation		Director temper 2. Foo by the 3/29/11	or regarding acceptable	e food hecked irector on and	
C S S S S S S S S S	Observation with Co 12:00 p.m., in the kit steam table, revealed solding temperature 41 degrees F (Fahr Chicken breasts a Creamed corn at 1	ok #1 on March 28, 2011, at chen at the tray preparation d three hot food items with a below the required minimum enheit). t 128 degrees F. 130 degrees F. a mechanical diet at 128		3. The re-educ Nutritic Regions minimu potentia policy a	s. No residents were a Nutrition Services Sta atcd on 3/30/11 by the mal Service Director a la Dietician regarding in internal temperature ally hazardous foods and procedure on checking food temperatures.	offected. If were and bot-held bes for and the	

Interview with Cook #1, at the time of the

DEPAR	RTMENT OF HEALT	HAND H AN SERVICES				PRINTE	D: 04/04/20	011
CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			2. 20.80	FOR	M APPROV O. 0938-03	ED
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION	(X3) DATE		<u> </u>
		445276	B. WIN	3				
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE		/30/2011	
CUMBE	RLAND VILLAGE CA	RE AND REHABILITATION CENT	ER	136 DAV	S LANE ETTE, TN 37766			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETIC DATE	ON
F 322	Continued From pa	age 2	F 32	22			1	\dashv
F 371 SS=F	floor. 483.35(i) FOOD PE	sconnect, and verified the e changed after touching the ROCURE, /SERVE - SANITARY	F 37	4. The checked weeks Directed times	food temperatures will d prior to (2) meals day by the Nutritional Serv or or Dietary Staff, then weekly for (4) weeks.	ily for (2) rice a (3) The food		
	The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, of under sanitary cond	m sources approved or tory by Federal, State or local distribute and serve food itions		temper to the I Comm The Pr consist of Nur Assista Directo Case M	ature findings will be reprocess Improvement ittee monthly for (3) mocess Improvement Cos of the Administrator, sing Services, Medical and Administrator, Assistrator of Nursing Services lanager, MDS Coordin Information Manager,	eported onths. mmittee Director Director, stant , Clinical		
i	by: Based on observation falled to maintain the of three hot food iter steam table. The findings included	T is not met as evidenced on and interview, the facility proper holding temperature ins on the tray preparation of:		Office Laundr Nurse, Activiti Consul	Manager, Housekeepin y Supervisor, Infection Social Service Director es Director, and Pharm tant. Subsequent plans on will be implemented ry based on the observa	g and Control , nacy of d as		
	steam table, revealed to table,	chen at the tray preparation of three hot food items with a below the required minimum enheit). 128 degrees F. 30 degrees F. a mechanical diet at 128					4/18/11	
3.1	nterview with Cook #	1, at the time of the						

DEPARTMENT OF HEALTH	AND H' AN SERVICES			PRINTER	0: 04/04/2011
CENTERS FOR MEDICARE	& MEDI ID SERVICES			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION). 0938-0391 SURVEY
1	445276	B. WING			
NAME OF PROVIDER OR SUPPLIER	440276				30/2011
CUMBERLAND VILLAGE CARI	E AND REHABILITATION CENT	ER Í	REET ADDRESS, CITY, STATE, ZIP COD 136 DAVIS LANE -AFOLLETTE, TN 37766	PΕ	
PREFIX : (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371 Continued From pag	e 3	F 074			
	ed the food temperatures	F 371 F 441	F 441 - (D)		
Infection Control Prosafe, sanitary and control help prevent the desort of disease and infection Control of The facility must estand Program under which (1) Investigates, control in the facility; (2) Decides what processhould be applied to a (3) Maintains a record actions related to infections related to infection determines that a resign prevent the spread of isolate the resident. (2) The facility must procommunicable disease from direct contact will transicate the facility must resident (3) The facility must resident contact will transicate the facility must resident (3) The facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility must resident contact will transicate the facility and the facility must resident contact will transicate the facility and the	Program blish an Infection Control it - rols, and prevents infections redures, such as isolation, an individual resident; and of incidents and corrective ctions. of Infection Control Program dent needs isolation to infection, the facility must ohibit employees with a e or infected skin lesions in residents or their food, if emit the disease, quire staff to wash their it resident contact for which ited by accepted		1. Resident #23's nose bleed managed and the blood spill floor was cleaned using a blood kit by the CNA on 3/28/11. #13 was assessed by the Din Nursing Services on 3/29/1 adverse findings. Resident suction catheter (tool) was occurred supply clerk on 3/28 feeding tubing for Resident changed by the Director of 18 Services on 3/29/11. LPN # provided re-education on 3/2 the Regional Director of Cli Operations regarding infectite technique related to percutar endoscopic gastrostomy (PE LPN #1 was re-educated by Director of Nursing Services regarding infection control procedure for cleaning blood and maintaining clean technique direction administration we gastrostomy tubes. Central scaler was re-educated on 3/2 the Director of Nursing Servinfection control regarding pand storage of oral suction care	I on the lood spill Resident rector of I with no #13's oral changed by /11. The #13 was Nursing #1 was 29/11 by nical on control neous (G) tubes, the s on 4/1/11 oractices, I spills, ique for ith supply 8/11 by ice on reparation	

DEPAR	RTMENT OF HEALT ERS FOR MEDICARI	H AND HI " 'AN SERVICES E & MEDI. "D SERVICES				PRINTE FORI	D: 04/04/2011 M APPROVED
PAINTEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		NSTRUCTION	(X3) DATE	D. 0938-0391
		445276	B. WING		,	1	
NAME OF	PROVIDER OR SUPPLIER					03/	30/2011
		RE AND REHABILITATION CEN	TER S	136 DAVI	DRESS, CITY, STATE, ZIP CODE S LANE ETTE, TN 37766		
(X4) ID PREFIX TAG	(SOUTH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOSS-REFERENCED TO THE APPI DEFICIENCY)	JIIDBE	(X5) COMPLETION DATE
F 441	i i	ge 4 IT is not met as evidenced	F 44	Assist Servic Coord	Director of Nursing Se ant Directors of Nursing es, or Staff Developmer mator will interview (3)	it random	
:	Based on medical refacility policy review failed to follow the p for one resident (#2: sanitary conditions f maintain clean technone resident (#13) or reviewed. The findings included Resident # 23 was a	ecord review, observation, and interview, the facility olicy for cleaning a blood spill, 3), and failed to maintain or a suction catheter and hique for a tube feeding for f thirty-two residents		then (1) to mon proced The Di Assista Service Coordi cathete storage tube me opportu infectio	yees per week for (4) we) time monthly for (2) re- itor staff knowledge of ure for cleaning blood serector of Nursing Service and Directors of Nursing es, or Staff Development nator will observe suctions for appropriate dates of a procedures, and gastrosedication administration unities to monitor for control procedures (3)	eeks, nonths the pills. tes, ton and tomy	
o d d re ai ol pa	esident #23 sitting or Certified Nursing Assatop a nosebleed with vash cloth. Continued in the floor next to the oorway, and on the esident's room. Observatical Nurse (LPN) etrieved paper-towels thempted to wipe block paper towels in the ball aper towels in the ball ithout washing hands om. Continued observation revealed I	he initial tour, in the secure 11, at 9:15 a.m., revealed in the side of the bed and a stant (CNA) attempting to a gloved hands and a wet dobservation revealed blood is bed, across the floor to the door frame entering the envation revealed Licensed #1 entered the room, is and with ungloved hands bed from the floor. Continued LPN #1 tossed the soiled throom trash can and is, exited the resident's revealed LPN #1 trieve bleach from the floor.		monthly Nursing of Nursi findings procedu Improve three mo Improve Adminis Nursing Manager Manager	for (4) weeks and (1) tilly for (2) months. Direct Services or Assistant Direct Ing Services will present from infection control re monitoring to the Proment Committee month onths. The Process ment Committee consistinistrator, Director of N. Medical Director. Assistant Directo Services, Clinical Case, MDS Coordinator, He ion Manager, Business (1) Housekeeping and Lauor, Infection Control Nu	cess ly for ursing stant rs of alth Office	

DEPA	RTMENT OF HEALT	HAND H' 'AN SERVICES				PRINTE	D: 04/04/201
CENT	ERS FOR MEDICARI	E & MED, ID SERVICES				FOR	M APPROVE
AND PLA	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V. BUI		NSTRUCTION	(X3) DATE	O. 0938-039 SURVEY PLETED
		445276	B. WIN	ig		1	
NAME OF	PROVIDER OR SUPPLIER					03	/30/2011
		RE AND REHABILITATION CENTE	.R	136 DAV	DRESS, CITY, STATE, ZIP CODE IS LANE LETTE, TN 37766		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	lb PREFIX TAG	< ·	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH COSS-REFERENCED TO THE APP	OULDEE	(X5) COMPLETION DATE
OF 9 In the	containing "bleach vobservation revealed #1 handed the bottle 9:51 a.m., revealed room and retrieved the kit to clean the firesident's room. Review of the facility clean-up revealed, "cleaning and decont kit located in medical nursing station, or provided in the facility clean, in the resident's had not followed the blood spill. Resident #13 was read January 22, 2011, with Effects of Cerebral Valley Hypertension, Diabete and Dysphasia. Control of the Minimum Data revealed the resident percutaneous endosciube, and was dependent in the process of the Minimum Data revealed the resident percutaneous endosciube, and was dependent percutaneous endosciube.	resident's room at 9:45 a.m., reper delivered a bottle vater" to LPN #1. Continued d LPN et to the CNA. Observation at the CNA exited the resident's a blood spill kit and utilized foor and the door frame of the discording procedures use tion room, emergency cart, e-identified area." 1 on March 28, 2011, at 9:52 is room, confirmed LPN #1 facility's policy for cleaning a admitted to the facility on the diagnoscent including the	F 4	41 Social Direct Subsectimplen	Service Director, Activor, and Pharmacy Consiquent plans of correction mented as necessary bas servation results.	vities ultant.	4/18/11

ATEMENT OF DEFICIENCIES	RE & MED. ID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM OMB NO	0038-0
D PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S	URVEY
	445276	B. WING		_	
ME OF PROVIDER OR SUPPLIER				03/3	0/2011
	RE AND REHABILITATION CENT	'ER 136	ET ADDRESS, CITY, STATE, ZIP COI DAVIS LANE FOLLETTE, TN 37766	DE	
	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	CHOUR DE	(X5) COMPLETI DATE
F 441 Continued From pa	3 ans		DEFICIENCY)	- INOPRIME	DATE
: large clear plastic i	pag. Continued observation	F 441			
observation confirm	PN #2 at the time of ned the suction catheter was 1 (25 days) and stated "it changed."				
disconnected the tule the tubing over the self-ushed the PEG. Concerved the tubing in the tubing on the bedside, wiped the tubing on the bedside, wiped the full disconnected the tubing on the bedside, wiped the full disconnected the tubing on the bedside, wiped the full disconnected the tubing on the bedside, wiped the full disconnected the tubing on the bedside.	cations to the resident. ion revealed LPN #1 bing from the PEG, draped side rail of the bed, and continued observation had fallen to the floor. revealed the LPN #1 layed d mattress, went to the ling with the west				
Interview with the Dir	ed the tubing to the PEG.				
Interview with the Dir Assistant Director of at 2:25 p.m., in the Directorique was not for	ector of Nursing (DON) and Nursing on March 29, 2011, ON's office, confirmed clean llowed for the tube feeding and the tubing procedule.				
Interview with the Director of at 2:25 p.m., in the Director in technique was not for disconnect and verifie	ector of Nursing (DON) and Nursing on March 29, 2011, ON's office, confirmed clean llowed for the tube feeding and the tubing procedule.				
Interview with the Director of at 2:25 p.m., in the Director in technique was not for disconnect and verifie	ector of Nursing (DON) and Nursing on March 29, 2011, ON's office, confirmed clean llowed for the tube feeding and the tubing procedule.		¥		